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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DENA LEANN HANSEN** **2859 Yard Street** **Oroville, CA 95966** **Registered Nurse License No. 394550** Respondent.	Case No. 2013-222 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board").

2. On or about February 28, 1986, the Board issued Registered Nurse License Number 394550 to Dena Leann Hansen ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2013, unless renewed.

JURISDICTION

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY AND REGULATORY PROVISIONS

5. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

7. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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CAUSE FOR DISCIPLINE

(Gross Negligence)

9. At all times relevant herein, Respondent was employed as a charge nurse on the NOC (night) shift at Shadowbrook Health Center ("Shadowbrook"), a skilled nursing facility located in Oroville, California.

10. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that Respondent committed acts constituting gross negligence in her care of residents A through F as defined in Regulation 1442, as follows:

Resident A

a. The resident had a physician's order starting on August 18, 2008, to monitor the resident's whereabouts every two hours due to her wandering risk and potential of getting lost. On or about September 17, 21, 22, 23, 27 and 28, 2008, Respondent failed to monitor the resident's whereabouts every two hours or document in the resident's Treatment Administration Record that she carried out the physician's order.

Resident B

b. The resident had a physician's order starting on August 19, 2008, for an Albuterol/Atrovent unit dose hand held nebulizer treatment to be performed every 4 hours. On or about September 27 and 28, 2008, Respondent failed to administer the nebulizer treatment to the resident or document in the resident's Treatment Administration Record that she carried out the physician's order.

c. The resident also had a physician's order to administer oxygen to the resident at 4 liters per minute via nasal cannula continuously for COPD (chronic obstructive pulmonary disease). On or about September 17, 21, 22, 23, 27, and 28, 2008, Respondent failed to administer oxygen to the resident or document in the resident's Treatment Administration Record that she carried out the physician's order.

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Resident C

d. On or about September 28, 2008, Respondent wrote a pre-operative report or assessment in the nurses' progress notes which was not legible, thereby failing to communicate necessary medical information regarding the resident's medical condition prior to surgery.

Resident D

e. The resident had a physician's order for oxygen to be administered continuously except during ADL (activities of daily living) care and showers. On or about September 4, 27, and 28, 2008, Respondent failed to administer oxygen to the resident or document in the resident's Treatment Administration record that she carried out the physician's order.

f. The resident also had a physician's order for hand held nebulizer with Albuterol and Ipratropium to be administered every 6 hours around the clock at 6:00 a.m., 12:00 noon, 6:00 p.m. and midnight. On or about September 4, 27, and 28, 2008, Respondent failed to administer the nebulizer treatments to the resident or document in the resident's Treatment Administration record that she carried out the physician's order.

Resident E

g. The resident had a physician's order for oxygen to be administered continuously except during ADL care and showers. On or about September 4, 17, 27, and 28, 2008, Respondent failed to administer oxygen to the resident or document in the resident's Treatment Administration Record that she carried out the physician's order.

h. The resident also had a physician's order to apply "Zinc Oxide cream to shearing action area on left lateral hip each shift until healed". On or about September 27, and 28, 2008, Respondent failed to apply the Zinc Oxide cream to the resident's hip or document in the resident's Treatment Administration Record that she carried out the physician's order.

Resident F

i. The resident had a physician's order starting on September 21, 2008, to apply "Zinc Oxide cream to shearing action area, right lateral hip, each shift until healed". On or about September 27 and 28, 2008, Respondent failed to apply the Zinc Oxide cream to the resident's hip

or document in the resident's Treatment Administration Record that she carried out the physician's order.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 394550, issued to Dena Leann Hansen;

2. Ordering Dena Leann Hansen to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: SEPTEMBER 27, 2012

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
State of California
Complainant

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